Arizona Dept. of Health Services Division of Behavioral Health Services

Encounter Tidbits

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Providers Can Use New Web Application To Verify Eligibility, Check Claim Status

AHCCCS is unveiling a new Web application that allows providers to verify eligibility and enrollment and to check the status of fee-for-service claims using the Internet.

The Web-based application was made available to providers in stages. During the month of September, providers whose AHCCCS provider ID is in the 000001 – 051582 range were able to create an account to access the application. In October, providers whose AHCCCS provider ID is in the 051583 – 196578 range were able to create accounts.

To create an account and begin using the applications, providers must go to the AHCCCS Home Page at www.ahcccs.state.az.us. Once at the Home Page, click on the Information for Provider link to go to the Providers page. A link on the Providers page will allow providers to create an account and to view eligibility and claim information.

The site is secured through a security module developed by AHCCCS that requires a user login. VeriSign software is used to secure the data transferred over the Internet.

Once a provider has access to the site, the provider can query information relating to any recipient in the system. The Eligibility/Enrollment page will display the results of the search. The user can then navigate to the Benefits page to obtain Medicare/TPL information for a recipient.

Both pages will allow the user to view multiple records for the selected recipient.

To view claim status information, providers must enter a provider ID, recipient ID and dates of service. The provider will then navigate to a page displaying the claim header information. From this page, the provider will have the option to view detailed information relating to the claim, including status history, work actions, edit history and accounting summary.

The Claim Status page will also allow providers to search by claim number, patient account number, adjudication status and form type. If multiple records are returned from the search, the users will be able to scroll through each record using navigation buttons at the bottom of the screen.

There is no charge to providers for creating an account, and there is no transaction charge.

The final phase of the project will provide the ability to request and update provider demographic information. This phase of the project currently is under development.

For questions about the Web-base application, Please call the AHCCCS Customer Support Unit at (602) 417-4451.

Fraud and Abuse Reporting Protocol

There has been some concern regarding the number of fraud referral's being submitted to the Division of Behavioral Health Services (DBHS). Please be sure to refer any allegations of fraud, waste or abuse immediately to DBHS. DBHS will determine the next course of action for any referred cases. It is also imperative that RBHA employee's, as well as providers and members, know how and where to report suspicious activity. In addition to reporting fraud at the RBHA level, anyone who wishes to report an incident of suspected fraud and abuse may do so anonymously by calling Michael Carter, DBHS Fraud Investigator, at (602) 553-9075 or by e-mail at mcarter@hs.state.az.us.

ADHS/DBHS Fraud and Abuse Workgroup Scheduled for January

The next Fraud and Abuse Workgroup will be held on Tuesday, January 7, 2003. It will be located on the third floor in the Fir conference room. Teleconferencing will be available for those unable to make the trip. David Botsko (AHCCCS Chief Investigator) will be delivering a presentation on Fraud and Abuse.

AHCCCS Reduces Reimbursement Rate for "By Report Codes"

Effective October 1, 2002 reimbursement rates for By Report Codes decreased by 15%. By Report Codes are defined as procedure codes that have no assigned reimbursement rate. These codes are reimbursed at a percentage of the total amount billed. The new reimbursement rate for By Report Codes is 65% of the total amount billed.

SMI/SED Edit Functions Clarified

There has been some confusion regarding implementation of the new SMI/SED category of service edits. These edits were developed as a result of Policy 2.44 and are designed to perform various functions.

Intakes labeled with a mental health category of SMI or SED and flagged as special population intakes, are required to have a corresponding assessment in CIS. The assessment must match the intake date and contain a supporting diagnosis code for SMI or SED designation. SMI or SED intakes with no corresponding assessment will not be sent to AHCCCS.

Assessments submitted with an SMI or SED flag set, must have a supporting diagnosis code or they will not be accepted.

If an assessment is submitted with a diagnosis code that is approved for SED, the corresponding SED special population flag must also be checked or the assessment will not be accepted.

If an assessment is submitted with a diagnosis code that is approved for SMI, the corresponding SMI special population flag **does not** have to be checked. The diagnosis codes approved for SMI may also be used for non-SMI clients.

Currently the diagnosis codes for these edits must appear in either the Axis I Primary or Axis II Primary diagnosis code fields. A request has been forwarded to our Information Services Department to change the edits to include all Axis I and Axis II diagnosis code fields.

Example of a new edit: Diagnosis code 314.03, an SED diagnosis code, appears in the Axis II Secondary diagnosis code field. The corresponding SED special population flag must also be checked or the assessment will not be accepted.

Top Monthly Pended Encounters

R600 - Medicare Coverage Indicated But Not Billed
Encounters are pending because the TPL file indicates the recipient has Medicare coverage, but the claim has been submitted with the Medicare fields blank. If the TPL file indicates a recipient has Medicare, claims must be submitted with a dollar amount. If the service is not a Medicare covered service, zero must be entered in the Medicare fields. A zero value indicates Medicare did not cover the service or denied the service.

Z720-Exact Duplicate Found
Encounters are pending because at least one claim was found in the system that matches the pending claim. These claims need to be researched by the RBHA's to determine the cause for the exact duplicate. Multiple units of service for the same client on the same day should be combined. For example: If a client is seen for Peer Support twice in one day, W4048 should be billed on one claim with two units instead of two claims for one unit each.

P330-Provider Not Eligible for Category of Service
Encounters will pend for edit P330 when the provider is not eligible to bill for the indicated category of service on the date the service was provided. RBHA's should ensure the category of service matches the provider type (on the date of service) prior to submitting the encounter.

Encounter Pend Error Codes Which Must be Voided and Not Corrected

There are three encounter pend errors that must be voided instead of corrected. They are:

Error Code	Error Description
H270	Prior CRN not found or mismatched
H280	Encounter not eligible to adjust
H610	Previous CRN and adjustment/void code not both present

If further assistance is needed, please contact your assigned Technical Assistant at (602) 553-9085 (Javier Higuera) or (602) 553-9132 (Anita Delgado).

Encounter Unit Update

Edit A900
The A900 edit (unreasonable health plan paid amount) will require an additional three to six months of research prior to implementation.

AHCCCS TPL File
AHCCCS is currently scheduled to have their TPL file completed by April 2003. RBHA's should continue to pursue other means of verifying Medicare eligibility to keep pended encounters to a minimum.

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